



Message from the Chair  
Alan Armstrong

With the approach of fall, I hope our section members have quality time with their families. Many years ago, I clerked for Charles Longstreet Weltner, and he reminded me that “the law is a jealous mistress.” That assessment is accurate. Our work is very demanding. The necessity to continually perform on a high level and sacrifice time with our families in order to achieve in the law practice presents its challenges to personal relationships. Conversely, without the law, many of us would not find our lives fulfilling. It is an intellectually challenging and rewarding endeavor which, from time to time, can even challenge our courage and resolve. For those of you out there in the trenches, taking depositions and arguing motions every day, I hope you find balance in your personal lives as well as professional fulfillment.

I am delighted to report that this edition will present two authors who have taken the time to write articles for our Newsletter. The first is Smith T. Johnston, Esq. who has written an article: *A Brief Review of the July 2022 Complaint of J. Chambers et al v. Airshare, Miller, Hall & Bombardier, Commonwealth of Massachusetts, Suffolk Superior Court Civil Action File No. 2684CV02043*. In this article, Mr.

Johnston compares and contrasts allegations in the complaint with excerpts from the National Transportation Safety Board Final Report in Accident No. ERA23LA135. This is an interesting work, and I trust you find his analysis meaningful.

Our second author is Scott Ledford, Esq. who has written: *Aircraft In Divorce and Estate Planning: Federal Registration Traps for Georgia Practitioners when Family Law and Estate Planning Meet the FAA Registry*. This is an interesting piece examining the requirements of the FAA with respect to the formalities and requirements of aircraft registration.

November 15, 2026, will mark 50 years at the bar for the undersigned. Most of those 50 years were spent practicing Aviation Law. It has been a very rewarding but sometimes very challenging endeavor. One of the real bonuses of this line of work is the caliber of people you meet in your professional world. I hope when each of you arrive at the 50-year mark, you can look back on those years of practice with the level of satisfaction I find in contemplating the people I met, the judges I appeared before, and the friends I made.

Happy Landings,

Alan

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Newsletter Reminder

Please submit content by Dec. 1 for inclusion in the Winter 2026 edition, which will be published in mid-December. Please ensure you have permission to share submissions and that they adhere to all State Bar policies. Email Mary Newton, Aviation Law Section newsletter editor, with submissions, suggestions or questions: [mary@mnewtoncommunications.com](mailto:mary@mnewtoncommunications.com).

# **A Brief Review of the July 2026 Complaint of *J. Chambers, et. al. v. Airshare, Miller, Hall, & Bombardier*, Commonwealth of Massachusetts, Suffolk Superior Court Civil Action No. 2684CV02043**

*Smith T. Johnston, Esq.\**

## **INTRODUCTION**

On July 13, 2026, a complaint was filed in Suffolk Superior Court of the State of Massachusetts for the wrongful death of Dana Hyde who perished in a mid-air flight incident on March 3, 2023.<sup>1</sup> (Henceforth cited in-line as “*Comp.* ¶ #”). The incident was widely reported at the time in 2023, not least in part because the decedent was a former attorney at some of the highest levels of the federal government, and fatalities due to turbulent episodes are relatively rare occurrences.<sup>2</sup>

This short article merely reviews the complaint and attempts via footnotes to compare pertinent points of the complaint with excerpts of the NTSB Final Report (Accident Number/NTSB #: ERA23LA135), which was published on December 5, 2024.<sup>3</sup> (Henceforth cited as “*NTSB Final Report*, p. #”). As of the writing of this Article in August 2026, only the July 2026 Complaint and 2024 NTSB Final Report are reviewed and commented upon herein.

## **I. BACKGROUND ALLEGED FACTS**

According to the Complaint, Dana Hyde, her husband Jonathan Chambers, and one of their children, Elijah, were passengers on a Bombardier Challenger 300 (BD-100-1A10, Reg. No. N300ER) business jet-aircraft, owned by Conexon LLC and operated by pilot-in-command (“PIC”) Miller and second-in-command (“SIC”) Hall, both employees of an aircraft operator identified as Executive Flight Services, LLC, d/b/a Airshare (“Airshare”), for a planned 1 hour 20 minute, non-revenue Part 91 flight on March 3 from Keene, New Hampshire, to Leesburg, Virginia, which routed through Massachusetts airspace. (*Comp.* ¶¶ 34-37).

After departure, the Challenger reached a speed of 276 KIAS and a leveled flight after climbing to an altitude of approximately 23,000 ft. (*Comp.* ¶¶ 104, 107). Shortly after leveling, at approximately 4:00 p.m. local time, Dana Hyde got up from her seat to use the restroom, when the aircraft experienced a violent upset, causing Hyde to be thrown violently against the interior of the aircraft, resulting in fatal injuries. (*Comp.* ¶¶ 107-08, Introduction). Jonathan Chambers and Elijah alerted the Airshare crew (PIC Miller and SIC Hall) of the emergency. (*Comp.* ¶ 109).

The Airshare crew contacted air traffic control which directed them to land in Windsor Locks, Connecticut, where an ambulance would be dispatched for their arrival. (*Comp.* ¶¶ 109-11). After landing, Hyde was transported to a nearby hospital and was declared dead at 6:18 p.m. as a result of the blunt force trauma suffered during the aircraft’s mid-air loss of control and violent oscillations. (*Comp.* ¶¶ 113-14).

## **II. SPECIFIC ALLEGATIONS OF NEGLIGENCE AND LIABILITY**

The plaintiffs include Jonathan Chambers, as representative of Dana Hyde’s estate, and as an individual, and Elijah Chambers and Judah Chambers, as individuals, both of whom are decedent’s children. The defendants include Airshare, Miller, Hall, Bombardier, Inc., and Bombardier Aerospace Corp. (Conexon LLC<sup>4</sup> is not included as a defendant apparently because Conexon, as the owner of the aircraft, merely contracted with Airshare which provided the operations and services of the aircraft at issue). (*Comp.* ¶ 36).

In general, the Complaint asserts that the plaintiffs’ claims arise from the negligent conduct of Airshare and its flight crew (*i.e.*, PIC Miller and SIC Hall), and from the defective and inadequate condition of the Bombardier defendants’ Airplane Flight Manual (“AFM”) and related manuals and checklists for the subject aircraft, the Bombardier Challenger 300, adherence to which is required by the flight crew to ensure the airworthiness of a flight. (*Comp.* ¶ 33).

Regarding the subject aircraft and its proper operation, the Airshare flight crew was trained and required to operate the Bombardier Challenger 300 in accordance with a number of manuals and checklists, specifically: the aircraft’s AFM, Quick

Reference Handbook (“QRH”), Quick Reference Card (“QRC”), Minimum Equipment List (“MEL”), a GO/NO GO GUIDE, and an Airshare published General Operations Manual (“GOM”). (Comp. ¶¶ 38, 47). The subject aircraft was equipped with an Engine Indication and Crew Alerting System (“EICAS”), which includes a Crew Alerting System (“CAS”) that displays Warnings, Cautions, and Advisory messages to the PIC and SIC to alert them on the status of the aircraft’s systems, such as the status of the rudder, autopilot, trim conditions, and pitch attitude conditions. (Comp. ¶¶ 40, 42, 43). When there is an alert on the CAS, the PIC and SIC are required to address them according to the manuals and checklists identified above, which ensure the airworthiness of the aircraft and compliance with applicable federal regulations. (Comp. ¶¶ 41, 45, 46).

The Complaint alleges specific acts of negligence as follows.

**A. *Failing to Remove the Pitot Tube Cover***

First, the Complaint alleges that during the preflight inspection around 3:00 p.m. local time, although the SIC removed the left-side pitot tube cover(s), the SIC failed to remove the right-side pitot tube cover, which is an essential requirement for preflight compliance and airworthiness. (Comp. ¶¶ 49-52, 58).<sup>5</sup>

Next, for months before the subject flight, the right-sided pitot tube cover had been missing the bright red streamer with the written alert that reads “REMOVE BEFORE FLIGHT;” the Complaint includes several figures depicting the alleged condition at the time of the subject flight which shows the difference between a pitot tube cover with a streamer and a pitot tube cover without a streamer; this leads to the allegation that Airshare failed to ensure that the pitot tube cover with the missing streamer was replaced with a pitot tube cover with a streamer, which is a required condition according to federal regulations and the AFM and related manuals and checklists. (Comp. ¶¶ 52-55, Figures 1-4).

Additionally, on the day of the flight, the PIC failed to perform a “Final Walk-Around” inspection to ensure an airworthiness condition, which is also required by Airshare’s GOM. (Comp. ¶¶ 56-57).<sup>6</sup>

Thus, while taxiing down the runway for take-off, the SIC identified an anomalous condition from the Primary Flight Display (“PFD”) when it reported different speeds; whereupon the PIC aborted take-off and depowered the left engine so that the SIC could walk around the aircraft to check for the anomaly, which the SIC identified as being explained by the failure to remove the pitot tube cover and so thereupon removed said cover and then reboarded the aircraft. (Comp. ¶¶ 59-61).<sup>7</sup>

**B. *Failing to Resolve the EICAS “RUDDER LIMITER FAULT” Message***

The Complaint asserts that the PIC and SIC failed to adequately investigate and resolve the “RUDDER LIMITER FAULT” (“RLF”) message displayed on the EICAS, prior to take-off. (Comp. ¶¶ 65, 68, 69, 70, 74).

Specifically, the Complaint alleges that the failure to remove the pitot tube cover (even after it was removed by the SIC after the aborted take-off described above), then caused the EICAS to display a “RUDDER LIMITER FAULT” message, which is unequivocally identified in the GO/NO-GO GUIDE (which is part of the Quick Reference Handbook (“QRH”)) that such a message means that the aircraft is not in an airworthy condition and cannot permissibly take-off (*i.e.*, a “NO-GO” condition). (Comp. ¶¶ 62, 66). The PIC attempted to clear the RLF using a non-specified procedure, which did not clear the RLF from the EICAS; the PIC also rejected the SIC’s advice to call Airshare Maintenance Control to address the issue; and so the crew proceeded to take-off while the RLF was so displayed. (Comp. ¶¶ 63, 68).<sup>8</sup>

Thus, the PIC and SIC did not consult the GO/NO-GO GUIDE, the MEL, or Airshare Maintenance Control to resolve the RLF, and so took-off while the RLF was displayed and therefore while the aircraft was in an unsafe and unairworthy condition, contrary to federal regulations, fundamental flight safety, the AFM, and Airshare’s GOP. (Comp. ¶¶ 65-72, 74, 88).<sup>9</sup> The Complaint alleges that this RLF condition was a direct and proximate cause of the in-flight violent in-air upset and of the death of Dana Hyde because the RLF disabled the automatic trim function

of the aircraft thereby causing the aircraft to be mis-trimmed when the autopilot was later engaged during flight. (Comp. ¶¶ 76-78).

### C. Negligence During Flight & Landing

The Complaint alleges multiple acts or omissions of negligence by Airshare, the PIC, and/or SIC during take-off and flight, and accounts the sequence of events leading up to the in-air incident.

As understood from the Complaint, as early as 10 seconds after take-off the crew received master caution alerts and in total throughout take-off received six master cautions on the EICAS, each accompanied by an aural alert sounding, in what appears to be the following approximate sequential order (Comp. ¶¶ 81-85, 86, 93, 95):

- |                                     |                                                                                                                                        |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| 1. RUDDER LIMITER FAULT             | -pre-take-off, described above;                                                                                                        |
| 2. MACH TRIM FAIL                   | -10 seconds after take-off, EICAS display,<br>Master Caution aural alert #1;                                                           |
| 3. Crew engages Autopilot (“AP”)    |                                                                                                                                        |
| 4. AP STAB TRIM FAIL                | -immediately after AP, EICAS display,<br>Master Caution aural alert #2;                                                                |
| 5. PIC makes pitch trim adjustment  |                                                                                                                                        |
| 6. AP disengages;                   |                                                                                                                                        |
| 7. PIC reengages AP                 | -seconds;                                                                                                                              |
| 8. AP STAB TRIM FAIL                | -seconds, EICAS display, Master Caution<br>aural alert #3;                                                                             |
| 9. AP HOLDING NOSE DOWN             | -21 seconds after PIC reengages AP,<br>EICAS display, Master Caution aural alert #4;                                                   |
| 10. PIC makes pitch trim adjustment |                                                                                                                                        |
| 11. AP disengages                   |                                                                                                                                        |
| 12. PIC reengages AP                | -seconds;                                                                                                                              |
| 13. AP STAB TRIM FAIL               | -EICAS display, Master Caution aural<br>alert #5; SIC tells PIC to leave the AP<br>off; PIC tells SIC to ‘get the checklist<br>going’; |
| 14. /15. AP HOLDING NOSE DOWN       | -EICAS display, Master Caution<br>aural alert #6.                                                                                      |
| 15. /14. PIC reengages AP           |                                                                                                                                        |

At this point there were four messages displayed on the EICAS (Comp. ¶ 87)<sup>10</sup>:

RUDDER LIMITER FAULT  
MACH TRIM FAIL  
AP STAB TRIM FAIL  
AP HOLDING NOSE DOWN

Although these messages were displayed on the EICAS,<sup>11</sup> the Complaint alleges, the crew negligently continued with the flight, accelerated the aircraft, and continued to climb, which increased control forces employed by the autopilot on account of the mis-trimmed condition, and the crew did not consider aborting the flight and/or returning to the airfield. (Comp. ¶¶ 87, 89, 90-95).<sup>12</sup>

The Complaint then alleges the Airshare crew’s conduct attempting to remedy the situation violated the standards of good airmanship, because the crew negligently executed the procedure for the incorrect master caution EICAS condition. (Comp. ¶¶ 96-97). Specifically, about 5 minutes after the 5<sup>th</sup> aural alert, the Complaint provides, the PIC asks the SIC to ‘run the checklist’ but the crew then executed the procedure for the “PRI STAB TRIM FAIL” condition instead of for the AP STAB TRIM FAIL or AP HOLDING NOSE DOWN conditions, as were

presented on the EICAS. (*Comp.* ¶¶ 96, 97-100).<sup>13</sup> This also appears to be a critical point in this case for grounds of liability against the Bombardier defendants. Notably, in referring to what checklists and procedures apply to the situation, the SIC referred to the Bombardier aircraft's Quick Reference Card (QRC), which is a folded laminated sheet with 4-sides that provides instructions for a limited number of EICAS messages and specifies immediate crew action prior to then consulting the more comprehensive Quick Reference Handbook (QRH), which is itself an abbreviated version of the multi-volume Airplane Flight Manual (AFM). (*Comp.* ¶¶ 96, 183-86, 187, 194). Importantly, the laminated two-page, four-sided QRC included a reference to the PRI STAB TRIM FAIL condition but it did not include references for AP STAB TRIM FAIL or AP HOLDING NOSE DOWN conditions. (*Comp.* ¶ 194). The Complaint alleges that this created the potential for confusing the Airshare crew about how to respond to the messaging from the EICAS. (*Comp.* ¶ 194). This appears to be an important discrepancy and a primary cause of the violent in-flight incident, because while the checklist to remedy the PRI STAB TRIM FAIL condition instructed the crew to move the stabilizer trim switch ("STAB TRIM") to "OFF," the autopilot was still engaged. (*Comp.* ¶¶ 98-100). It appears that when the crew executed this instruction this is what disengaged the autopilot and caused the abrupt change in control forces and loss of control of the aircraft, including the violent pitch variations. (*Comp.* ¶¶ 98-100).<sup>14</sup> Furthermore, even under the checklist/instruction for the PRI STAB TRIM FAIL condition, the crew is instructed to "HOLD FIRMLY" to the flight controls before turning STAB TRIM to OFF, because that procedure indicates that a potential abrupt change in control forces after doing so should be anticipated. (*Comp.* ¶¶ 100, 102). Here, it is also alleged that the PIC negligently failed to hold the flight controls firmly. (*Comp.* ¶ 102).<sup>15</sup> Notably, the "HOLD FIRMLY" instruction is also part of the correct and applicable procedure for AP STAB TRIM FAIL or AP HOLDING NOSE DOWN conditions, and so would also have been required of the PIC when executing the proper procedures/instructions. (*Comp.* ¶¶ 90-91).<sup>16</sup>

The Complaint further alleges that the Airshare crew should have ensured that the passengers were seated with their seatbelts fastened prior to performing the procedure just described. (*Comp.* ¶¶ 101, 98, 44, 101-107). Had the crew referred to the correct procedures (for correcting AP STAB TRIM FAIL and AP HOLDING NOSE DOWN conditions), they would have understood the critical importance of ensuring secure passengers against the effects described above, because each of the entries for these conditions (AP STAB TRIM FAIL and AP HOLDING NOSE DOWN) in the Quick Reference Handbook (QRH) warn of the possibility of abrupt changes in control forces in such situations and further specify that "SMKG/BELTS should be selected on." (*Comp.* ¶¶ 98, 90-91).<sup>17</sup> The Complaint asserts that Airshare's standard practice of leaving the illuminated seatbelt sign on at all times regardless of conditions resulted in the sign losing its meaning and purpose, and the crew was aware of this and of the regular practice of passengers using the restroom upon the aircraft leveling, even when the seatbelt sign was illuminated. (*Comp.* ¶¶ 105, 106). Thus, by the time the crew implemented the PRI STAB TRIM FAIL correction procedure by turning the STAB TRIM to OFF, also while the PIC negligently failed to hold the flight controls firmly, the aircraft had been in a leveled flight at an altitude of 23,000 feet, traveling at 276 KIAS, and Dana Hyde had gotten up from her seat to use the restroom, believing it safe to do so. (*Comp.* ¶¶ 98-107).

The Complaint continues that the multiple negligent acts and omissions described above caused the crew to lose control of the aircraft, wherein the nose violently and unexpectedly pitched up and oscillated, violently throwing Hyde against the interior of the aircraft, causing fatal injuries. (*Comp.* ¶¶ 101, 108, Introduction).<sup>18</sup> After this occurred, Elijah and Jonathan Chambers summoned help from the crew whereupon the SIC entered the cabin, observed Hyde's injured condition, returned to the cockpit, and contacted air traffic control ("ATC") for emergency medical services. (*Comp.* ¶¶ 109-111).<sup>19</sup> The Complaint further alleges that Airshare was negligent when the Airshare crew, in communication with ATC, declined for the ambulance to meet them at the runway of the airport upon landing and instead instructed to meet them at the Fixed Base Operator's location instead, causing a material delay thereby. (*Comp.* ¶¶ 112, 113-114).

#### ***D. Bombardier's Allegedly Defective Aircraft***

The substance of the allegations against the Bombardier defendants is contained in Section II of the Complaint, wherein it is alleged that the subject aircraft's flight manuals and checklists were defective, and Bombardier's

conduct contributed to the in-flight mishap at issue by failing to provide adequate warnings and instructions concerning the messages displayed on the EICAS;<sup>20</sup> all of which culminate into specific claims for breach of implied warranty of merchantability, strict product liability and other applicable law, and negligent infliction of emotional distress. (*Comp.* ¶¶ 181-211, 212, 215, 219, 228, 236, 243, Introduction).

More specifically, the Complaint asserts that the Quick Reference Card (QRC) confused the crew when it contained a reference to the PRI STAB TRIM FAIL condition but did not contain a reference to the AP STAB TRIM FAIL or AP HOLDING NOSE DOWN conditions. (*Comp.* ¶¶ 194, 206).<sup>21</sup> Significantly, the Complaint shows that in 2024 (recall that the incident occurred on March 3, 2023) Bombardier modified its checklists and manuals in several ways: by designating AP STAB TRIM FAIL as an “Emergency Procedure”; creating a new section titled “Auto Flight”; adding a warning to the AP STAB TRIM FAIL procedure that ‘high forces may result from implementation of the checklist’; adding the AP STAB TRIM FAIL procedure to the Quick Reference Card (QRC) and removing the PRI STAB TRIM FAIL procedure from the QRC; adding warnings to the PRI STAB TRIM FAIL procedure similar to the warnings of the AP STAB TRIM FAIL procedure concerning the potential for ‘an abrupt change in control force’ or ‘out of trim situation’; and modifying the Introduction section of the AFM and QRH by adding a section entitled “DISPATCH” that clarifies requirements and procedures for properly clearing EICAS messages, including GO and NO GO conditions. (*Comp.* ¶¶ 195, 196, 198, 200, 202). Crucially, the Complaint alleges that the data prompting these changes in 2024 were based on multiple reported events prior to the in-flight incident at issue in this case in March 2023, and that these 2024-changes were all feasible and should have been made prior to the March 2023 incident. (*Comp.* ¶¶ 205, 199, 201, 203). Furthermore, the Complaint alleges that it was foreseeable that pilots would be confused by the color scheme (Cyan/blue-colored) of a RUDDER LIMITER FAULT (RLF) message on EICAS and the RLF’s presentation in the AFM and QRH when compared with other blue advisories in the AFM and QRH. (*Comp.* ¶¶ 193, 204).<sup>22</sup>

These allegations culminate into the allegations that the Bombardier defendants sold a dangerously defective aircraft and failed to update and revise the AFM and related manuals and checklists after the initial sale, thereby breaching the implied warranties for airworthiness, merchantability, fitness for ordinary design purposes, and intended manufactured use; for non-defective manuals/checklists; and for proper, adequate, and correct instructions and warnings; all of which caused decedent’s death. (*Comp.* ¶¶ 207-211).

### III. SPECIFIC LEGAL CLAIMS ASSERTED

The specific legal claims asserted against each defendant by each plaintiff are formulated in the paragraphs concluding each section. (*Comp.* ¶¶ Section I, 123-180; Section II, 212-250).

In summary, plaintiff Jonathan Chambers, as representative of decedent Dana Hyde’s estate, asserts claims of wrongful death (*Comp.* ¶¶ Counts I-III & XI, 123-30, 212-14), and conscious pain and suffering (*Comp.* ¶¶ Counts IV & XII, 131-33, 215-18), against all defendants: Airshare, Miller, Hall, Bombardier Inc., and Bombardier Aerospace Corp. This plaintiff also asserts a claim of punitive liability against defendants Airshare, Miller, and Hall (*Comp.* ¶¶ Count V, 134-39), as well as a claim of misrepresentation against defendant Airshare (*Comp.* ¶¶ Count X, 172-80).

Each of the individual plaintiffs, Jonathan Chambers, Elijah Chambers, and Judah Chambers, assert claims of negligent infliction of emotional distress against all defendants: Airshare, Miller, Hall, Bombardier Inc., and Bombardier Aerospace Corp. (*Comp.* ¶¶ Counts VI, VIII, IX, XIII, XV, & XVI, 140-48, 157-63, 164-71, 219-27, 236-42, 243-50).

And individual plaintiff Jonathan Chambers additionally asserts claims for consequential damages against all defendants: Airshare, Miller, Hall, Bombardier Inc., and Bombardier Aerospace Corp. (*Comp.* ¶¶ Counts VII & XIV, 149-56, 228-35).

### CONCLUSION

The unusual nature of the event, the high profile of the decedent, the presence of the manufacturer as a defendant, the technical sophistication of the proximate inter-related parts, the potential consequences on the business-jet community,

and the prominence of plaintiffs' counsel, guarantee that this case will be closely and carefully watched by the industry and global political power. Participating persons involved with the 2024 NTSB Final Report included representatives from Transportation Safety Board of Canada, Bombardier, Moog Aircraft, Airshare, Honeywell Aerospace, and the FAA. This may represent only a small fraction of the persons involved in the maintenance, inspection, engineering, design, procurement, and manufacturing of the aircraft's proximate components and systems, the faulty or negligent condition of perhaps some of which may have made the safe operation of the aircraft meaningfully less likely to begin-with. In this context, and in the context of potential invalidation of contractual and indemnification agreements, the litigation of this case may involve such things as peculiar third-party practice, apportionment-of-fault, joinder, and venue and jurisdictional issues. Furthermore, the complicated psychological jury-effects will be actively calculated, as such the liability exposure to civil nuclear verdicts will almost certainly be a factor.

*\*Smith T. Johnston, Esq., is an Associate Attorney of [Mozley, Finlayson, & Loggins LLP](#), practicing law in Atlanta, Georgia. His practice includes aviation law, products liability litigation, civil litigation, medical malpractice, subrogation litigation, and insurance coverage, in state and federal court. He is also the editor of the monthly newsletter, [Aerospace Events and Litigation Review](#). Any view expressed in this article is his own and should not be attributed to the Firm or any other of his associations.*

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1 Jonathan Chambers, Individually, and as Personal Representative of the Estate of Dana Hyde, Elijah Chambers, and Judah Chambers v. Executive Flight Services, LLC d/b/a Airshare, Daniel J. Miller, and Christopher E. Hall, Bombardier, Inc., and Bombardier Aerospace Corporation, Commonwealth of Massachusetts, Suffolk, Superior Court Civil Action No. 2684CV02043, Docket #1, Complaint and Demand for Jury Trial, July 13, 2026. <https://www.masscourts.org/>. (Accessed August 2026). (Henceforth cited in-line as "Comp. ¶ #").

2 Associated Press, *1 killed when business jet encounters severe turbulence* (March 4, 2023), <https://apnews.com/article/turbulence-business-jet-passenger-killed-connecticut-c2be5cec157c0341087683ea26a0e855> (Accessed August 2026). CBS News, *Jet in flight that left Maryland lawyer dead may have had 'trim issues': NTSB* (March 7, 2023), <https://www.cbsnews.com/baltimore/news/jet-turbulence-kills-passenger-dana-hyde-maryland-lawyer/> (Accessed August 2026) (Reporting that decedent Hyde had served as counsel for the 9/11 Commission; special assistant to the President; special assistant to the deputy U.S. attorney general; senior policy adviser at the State Department; and associate director at the Office of Management and Budget).

3 See <https://data.nts.gov/Docket?ProjectID=106816> (Accessed August 2026); <https://www.nts.gov/Pages/AviationQueryv2.aspx> (NTSB #: ERA-23LA135) (Accessed August 2026);

See also 49 CFR § 835.2 ("Pursuant to section 701(e) of the Federal Aviation Act of 1958 (FA Act), and section 304(c) of the Independent Safety Board Act of 1974 (49 U.S.C. 1154(b)) (Safety Act), no part of a Board accident report may be admitted as evidence or used in any suit or action for damages growing out of any matter mentioned in such reports.").

4 Cf. *Final NTSB Report*, pp. 15-16 ('Executive Flight Services (EFS), LLC. held a 14 CFR Part 135 air operator certificate and also offered whole aircraft management services. A representative of EFS reported that they managed the accident airplane and employed the flight crew. EFS reported that the flight was operated as a non-revenue 14 CFR Part 91 flight by the owner of the airplane, Conexon LLC. According to their website, Conexon was a broadband network design and construction firm based in Kansas City, Missouri.').

5 Cf. *NTSB Final Report*, p. 1 ('The flight crew flew the passengers to their destination the day before the accident, and were conducting the return flight the following day. During the exterior preflight inspection, the second-in-command (SIC) was interrupted by line personnel delivering ice to the airplane and inadvertently failed to remove the right side pitot probe cover. The flight crew completed the remainder of their preflight activities, boarded the passengers, and taxied for takeoff.').; see also *Id.*, p. 17 ('The aircraft was equipped with three pitot probes. Two of the pitot probes were located on the left side and the other was located on the right side, below the pilots' side windows.').; see also *Id.*, p. 7.

6 Cf. *NTSB Final Report*, p. 17.

7 Cf. *NTSB Final Report*, p. 1 ('During takeoff, the SIC observed an anomaly with his right side primary flight display (PFD) airspeed indicator and he called for the pilot-in-command (PIC) to abort the takeoff. The PIC aborted the takeoff and taxied the airplane off the runway onto a taxiway. The SIC suspected that he may have forgotten to remove the pitot probe cover, and while stopped on the taxiway with the right engine running, he exited the airplane and removed the cover. [¶] Data recovered from the airplane's flight data recorder (FDR) indicated that the crew aborted the takeoff 16 seconds after thrust application, and the airplane reached a maximum speed of 104 knots (kts) as indicated by the left PFD airspeed indicator. The right PFD airspeed indicator data was consistent with the pitot probe remaining covered.').; see also *Id.*, pp. 7-8.

8 Cf. *NTSB Final Report*, p. 1 ('While on the taxiway, the PIC began troubleshooting a Crew Alerting System (CAS) cyan (blue) "RUDDER LIMITER FAULT" advisory message. He also noticed that the flight director was stuck in a pitch mode. He conducted multiple avionics stall tests, which had cleared the message on past flights; however, he was unable to clear the advisory message. The SIC initially indicated that he would call maintenance control; however, after a short discussion with the PIC, both flight crew members agreed to continue the flight with the advisory message posted.').; see also *Id.*, pp. 4, 16-17, Figure 3.

9 Cf. *NTSB Final Report*, pp. 1-2 ('The flight crew did not consult the airplane's "Go/No-Go" guide, but if they had, they would have found that the Rudder Limiter Fault advisory message was a "No-Go" item, and that the Minimum Equipment List provided no relief to depart with that message displayed.');

see also *Id.*, pp. 18-19, Figure 5.

10 Cf. *NTSB Final Report*, p. 2 ('During the subsequent takeoff, the SIC noticed that the airplane's V-speeds were no longer referenced ("bugged") on the airspeed indicator, and he called the speeds from memory. When the airplane passed through about 400 ft radio altitude, an amber (yellow) caution "MACH TRIM FAIL" CAS message posted. The PIC turned the airplane on course and shortly after takeoff, turned on the autopilot (AP), after which the CAS immediately displayed an additional amber "AP STAB TRIM FAIL" caution message. During the climb to cruise altitude, the pilot disconnected the autopilot via his use of the horizontal pitch trim control wheel button. Following his trim adjustments and the resulting disconnect of the autopilot, he subsequently reengaged the autopilot two additional times. With each disengagement and reengagement, all AP-related caution messages would clear, and then reappear upon autopilot reengagement. Furthermore, during the second and third engagements, an additional "AP HOLDING NOSE DOWN" caution message was displayed as airspeed increased in the climb. [¶] According to the cockpit voice recorder (CVR), the SIC asked if the autopilot was failing to off, or if the PIC was disengaging the autopilot. The PIC informed the SIC that he disengaged the autopilot, but during the subsequent disengagements and reengagements, he never announced to the SIC that he was turning the autopilot on or off. The SIC advised the captain to not use the autopilot during the climb, to which the PIC agreed. [¶] Shortly after receiving the amber CAS caution messages, the PIC called for the SIC to "get the checklist," but did not call for a specific checklist by name. The flight crew then became fixated on reprogramming the V-speeds into the Flight Management System (FMS), as the SIC believed that the caution messages may have been related to a configuration problem with the V-speeds and FMS since they had cleared following the aborted takeoff.').

11 Cf. *NTSB Final Report*, pp. 3-4 ('Flight testing of the accident scenario conducted after the accident, in a like make and model airplane, confirmed that the series of CAS messages likely presented in-flight were "MACH TRIM FAIL" (at 400 ft radio altitude), "AP STAB TRIM FAIL" (upon autopilot engagement), and "AP HOLDING NOSE DOWN" (upon speed deviation from where the AP was engaged). The testing confirmed that the AP-related CAS messages would clear and then reappear upon autopilot engagement and airspeed changes.');

see also *Id.*, p. 3 ('According to the airplane manufacturer, the "MACH TRIM FAIL" caution message was inhibited by the airplane's avionics system and was not displayed to the flight crew on the CAS until the airplane was in the air (weight off wheels) and above 400 ft radio altitude.').

12 Cf. *NTSB Final Report*, p. 4 ('[D]espite the SIC questioning the decision to continue the climb to cruise after receiving the cascading CAS messages, the PIC continued the flight as planned. Additionally, the PIC failed to communicate with the SIC regarding his continued use of the autopilot during the climb even after receiving a warning from the SIC to not use the autopilot and agreeing with the SIC's comments. The PIC's continued use of the autopilot likely contributed to the SIC's difficulty in selecting the correct checklist, given that the AP-related caution messages would disappear each time the autopilot was disconnected, but would reappear once reengaged. [¶]').

13 Cf. *NTSB Final Report*, p. 2 ('About 8 minutes after the PIC called for the checklist, the SIC located the quick reference card (QRC) and the "PRI STAB TRIM FAIL" [Primary Stabilizer Trim Failure] checklist. The SIC reported in a postaccident interview that he selected this checklist because it was the only trim failure checklist on the QRC, and it seemed to address the root cause of the problem. Although there were multiple CAS messages displayed, he did not consider using any other checklist. [¶] The SIC reported that he visually showed the PIC the checklist, and they agreed to execute the checklist. The first action item was to move the stabilizer trim switch ("STAB TRIM"), located on the center console, from "PRI" (Primary) to "OFF." The SIC read the checklist item aloud and subsequently moved the switch to off.');

see also *Id.*, p. 4 ('The PIC did not call for a specific checklist to address the CAS messages, and when the SIC showed the checklist to the PIC for agreement before they completed it, neither identified the chosen PRI STAB TRIM FAIL checklist as incorrect. According to the CVR transcript, shortly after regaining airplane control, both crew members acknowledged that the autopilot should not have been used during the climb.').

14 Cf. *NTSB Final Report*, pp. 2-3 ('Flight data recorder (FDR) information indicated that, as soon as the switch position was moved, the autopilot disconnected, and the airplane, which had been in a 3° nose-up attitude, rapidly pitched up to 11° in one second. The normal acceleration then rapidly rose to 4g. The PIC then pushed the control column forward with at least 90 lbs of force, the airplane pitched down to a near nose-level attitude, and the normal acceleration was reduced to -2.3g. The control column was subsequently pulled back through neutral, and the airplane rapidly pitched up to over 20° nose-up and more than 4g of normal acceleration. The FDR then stopped recording as the inertial g switch was triggered by the loading. As a result, the full extent of the pitch event was not recorded. The airplane's maneuvering load factor limitation was +2.6g.');

see also *Id.*, pp. 10-11, Figure 1; see also *Id.*, pp. 25-26.

15 Cf. *NTSB Final Report*, p. 3 ('The PIC reported that, immediately before the pitch oscillations, his left hand was on the flight controls and his right hand was guarding the right side of the flight controls. He reported that he did not anticipate the airplane pitching up so rapidly, but he did expect the autopilot to disconnect upon turning the stabilizer trim switch off.');

see also *Id.*, p. 9.

16 Cf. *NTSB Final Report*, p. 4 ('Both the AP STAB TRIM FAIL and the AP HOLDING NOSE DOWN QRH checklists provided warnings about the airplane's out-of-trim condition when those messages were displayed and also warned that abrupt changes in control forces may be experienced when disconnecting the autopilot. The checklists required the flight controls to be held firmly and provided a caution to minimize changes to airspeed and configuration to minimize the out-of-trim state. It is likely that the accident would have been prevented had the pilots completed one of the AP-related checklists; however, the SIC and PIC agreed to complete the PRI STAB TRIM FAIL checklist, despite the CAS not displaying this message.').

17 Cf. *NTSB Final Report*, pp. 4-5 ('The fatally injured passenger's seatbelt was not fastened at the time of the in-flight upset. The PIC reported that the seatbelt sign was on for the entire flight, and that his regular practice was to never turn it off. The in-flight upset occurred near 23,000 ft, about 9 minutes into the flight. It is likely that the passengers had no expectation for the seatbelt sign to be turned off at any time during the flight, given that they regularly flew with this flight crew. As a result, the passengers had to use their own judgement regarding whether it was safe to get up

and move about the cabin. [¶] Had the flight crew chosen the correct QRH checklist, they would have been warned of the possible abrupt change in control force upon autopilot disengagement and could have ensured that the passengers were seated with seatbelts fastened before completing the non-normal procedure. Then, even if an in-flight upset occurred, serious injury likely could have been avoided entirely by each passenger simply being seated with their seatbelt fastened. There were no other serious injuries reported from any other occupant on board.’); see also *Id.*, pp. 12-13, 13 (‘The PIC reported in an interview that the seatbelt sign was on for the entire flight, and that it is his “normal operation” as the PIC to “never turn it off throughout the flight.” He further reported that he and the SIC frequently flew with this group of passengers.’).

18 *Cf. NTSB Final Report*, p. 3 (‘Postaccident download of the horizontal stabilizer trim electronic control unit (HSTECU) non-volatile memory found that [...] The series of faults introduced into the HSTECU following the aborted takeoff resulted in the crew receiving the “AP STAB TRIM FAIL” CAS caution message upon autopilot engagement, due to the HSTECU inhibiting the autopilot trim function of the stabilizer. With the autopilot engaged and the trim function inhibited, the autopilot subsequently alerted the flight crew to “AP HOLDING NOSE DOWN,” which was meant to alert the crew that the autopilot was on, but that the airplane was out of trim and the autopilot was holding additional load on the flight

controls.’); see also *Id.*, p. 5 (‘The National Transportation Safety Board determines the probable cause(s) of this accident to be: The flight crew’s failure to remove the right side pitot probe cover before flight, their decision to depart with a No-Go advisory message following an aborted takeoff, and their selection of the incorrect non-normal checklist in flight, which resulted in an in-flight upset that exceeded the maneuvering load factor limitations of the airplane and resulted in fatal injuries to a passenger whose seatbelt was not fastened. Contributing to the severity of the in-flight upset were the pilot-in-command’s (PIC) decision to continue the climb and use the autopilot while troubleshooting the non-normal situation, and the PIC’s pilot-induced oscillations following the autopilot disconnecting from the out-of-trim condition. Also contributing to the accident was the crew’s inadequate crew resource management.’); see also *Id.*, p. 23 (‘Review of weather conditions along the route of flight revealed found no evidence of convective activity, nor any evidence of significant turbulence (reported or forecast). [¶] The flight crew reported that they did not experience any remarkable turbulence during the flight, or during the time immediately surrounding the in-flight upset.’).

19 *Cf. NTSB Final Report*, p. 3 (‘Shortly after the in-flight upset, the flight crew were alerted to a passenger that had been seriously injured. The SIC exited the flight deck to check on the passenger and to provide medical attention. He subsequently informed the PIC that there was a medical emergency and that they needed to land. About 17 minutes after the in-flight upset, the flight landed at the diversion airport. Later that day, the passenger succumbed to her injuries sustained during the in-flight upset.’); see also *Id.*, pp. 9-10; see also *Id.*, p. 24 (‘The Federal Bureau of Investigations Evidence Response Team sent an agent to the airplane the day of the accident. Photographs showed loose items scattered about the cabin. Some cabin shelving had broken inside of storage cabinets. Above the location of the No. 2 passenger, a part of the curved wood paneling and padded ceiling was cracked and displayed evidence of denting. Additional ceiling dents were located near the last row of seats and aft area of the cabin. Multiple oxygen masks had deployed from the ceiling. There was no evidence of any seat belts breaking free from their attachment points. [...] [¶] According to the State of Connecticut, Office of the Chief Medical Examiner, the passenger’s cause of death was blunt injuries of head, neck, torso, and extremities, and the manner of death was stated as, “Accident (unbelted on plane in flight).”’).

20 *Cf. NTSB Final Report*, p. 5 (‘The sequence of events that ultimately led to the accident originated with the flight crew’s failure to remove the right pitot probe cover before takeoff and their subsequent decision to depart with a No-Go CAS message. Although the message was advisory and not cautionary in nature, the airplane was indirectly alerting the flight crew to additional faults that had been introduced into the airplane’s systems following the aborted takeoff. The crew’s continuation of the flight with an unairworthy airplane directly contributed to the subsequent series of CAS messages, which the crew mis-diagnosed during the climb, resulting in the in-flight upset and loss of airplane control.’).

21 *Cf. NTSB Final Report*, p. 9 (‘The SIC, via an electronic flight bag (EFB), located the quick reference card and the PRI STAB TRIM FAIL [Primary Stabilizer Trim Failure] checklist. The SIC reported in a postaccident interview that he selected the PRI STAB TRIM FAIL checklist because, “...it’s the only trim fail checklist in the quick reference [card] and it seemed to be the root cause of our problem.” [¶] The SIC reported that he visually showed the PIC the checklist on the EFB, and they agreed to execute the checklist. The first action on the checklist was to move the stabilizer trim switch (STAB TRIM), located on the center console, from “PRI” (Primary) to “OFF.” The SIC read the checklist item aloud and subsequently moved the switch to the off position.’); see also *Id.*, p. 20 (‘According to the Bombardier QRH, the Quick Reference Card (QRC) was described in part as: *Procedures that contain Immediate Action Items, are shown within a box with a red-dashed border, and are also provided on the Quick Reference Card (QRC). The QRC can be used by the crew to more efficiently perform the Immediate Action Items without relying solely on memory, thus reducing the possibility of omission or commission errors. The QRC contains only the Immediate Action Items from the QRH, it does not contain the entire procedure.*’).

22 *Cf. NTSB Final Report*, p. 8 (‘While the SIC was retrieving the pitot probe cover, the PIC observed a Crew Alerting System (CAS) cyan advisory “RUDDER LIMITER FAULT” message. The PIC reported that he attempted two avionics stall tests (STALL/ RUD LIM test) to clear the message, as he had received this advisory message on previous flights in environments where the airplane was cold soaked; however, the tests did not clear the annunciation. [¶] The cockpit voice recorder (CVR) captured the flight crew discussing the Rudder Limiter Fault message and that the flight director was in pitch mode. After the SIC observed the Rudder Limiter Fault CAS message, he stated, “I’ll call ‘em,” and the PIC responded with, “who you calling?” The SIC stated, “do you want to take off with a rudder limiter fault?” The PIC responded with “it’s advisory only.” Their discussions continued briefly and eventually both agreed to continue the flight with the advisory message displayed.’); see also *Id.*, pp. 18-19, Figure 5; see also *Id.*, p. 20 (‘The [Airshare General Operations Manual] described multiple EICAS message types, including the two noted below: [¶] **Caution messages** - Are associated with serious system malfunctions that require immediate crew awareness and subsequent action when time and conditions permit. [¶] **Advisory messages** - Are associated with a loss of system redundancy that requires crew awareness and where subsequent action may be needed’).

# Aircraft in Divorce and Estate Planning: Federal Registration Traps for Georgia Practitioners When Family Law and Estate Planning Meet the FAA Registry

*Scott M. Ledford\**

## I. INTRODUCTION

Aircraft can occasionally appear in divorce, probate, and estate planning matters as if they were ordinary titled personal property. They are not. A settlement agreement, final decree, will, or trust may determine who is entitled to the aircraft as between the parties, but it does not by itself update the Federal Aviation Administration registry, clear recorded security interests, satisfy insurance requirements, or resolve federal eligibility questions. For the Georgia practitioner who handles family law or estate planning only occasionally involving aircraft, the important point is simple: the aviation paperwork must be addressed at the drafting stage, not after the dispute appears to be over.



## II. WHY AIRCRAFT TRANSFERS ARE DIFFERENT

An aircraft transfer generally requires more than private agreement. In a conventional sale, the seller commonly executes FAA Form AC 8050-2, Aircraft Bill of Sale, and the buyer submits FAA Form AC 8050-1, Aircraft Registration Application. Names should match the existing registration, authority to sign should be documented, and the aircraft records should support the ownership chain. In domestic relations and estate matters, the same issues arise in less conventional settings: one spouse may be ordered to transfer title, an executor or trustee may need authority to sign, or an heir may believe succession documents are enough. They may not be.

## III. DIVORCE: VALUE, POSSESSION, AND SIGNATURES

In divorce, valuation should begin with more than a marketplace estimate. Counsel should request logbooks, engine and propeller times, annual inspection status, damage history, avionics information, hangar or tie-down agreements, insurance declarations, loan documents, and any maintenance discrepancies that may affect value. If the aircraft is to be awarded to one spouse, the decree should identify who will prepare and sign FAA transfer documents, who will deliver the logbooks and records, who will maintain insurance during the transition, and what remedy applies if a required signature is withheld.

## IV. LIENS, LOANS, AND INSURANCE

Aircraft are sometimes financed, and recorded security interests should be checked before any transfer language is finalized. A divorce decree allocating debt between spouses does not necessarily release a borrower from an aircraft loan or satisfy a lender's consent requirements. Likewise, insurance should be addressed before possession changes. A lapse, misdescribed ownership interest, or unauthorized pilot issue could create practical problems that far exceed the cost of careful drafting.

## V. ESTATE PLANNING AND TRUST OWNERSHIP

Trust ownership presents its own set of aviation issues. Before placing an aircraft into trust, counsel should confirm that the proposed owner structure satisfies federal registration eligibility rules and that the trustee has clear authority to own, operate, insure, maintain, lease, sell, or dispose of the aircraft. A generic tangible personal property clause may not be enough. The governing instrument should also address who may operate the aircraft, who pays fixed and operating expenses, how records will be maintained, and what happens if continued ownership becomes impractical.

## VI. PRACTICE CHECKLIST

- Pull the FAA registry and confirm the registered owner, N-number, serial number, and any recorded liens.
- Review logbooks, inspection status, engine and propeller times, avionics, damage history, and maintenance issues.
- Identify who has authority to sign transfer documents, especially for an estate, trust, entity, or former spouse.
- Require execution and delivery of FAA transfer and registration documents as part of the settlement, decree, estate administration, or trust funding process.
- Address insurance, pilot qualifications, hangar rights, operating expenses, taxes, and lender consent before possession changes.

## VII. CONCLUSION

Not every family law or estate planning lawyer must become an aviation lawyer. However, when an aircraft appears on the asset schedule, ordinary drafting may be insufficient. A few aviation-specific provisions may prevent rejected FAA filings, unresolved liens, insurance gaps, and ownership disputes that surface only after the decree is entered or the estate plan is signed.

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## Revisiting the Tenets of Preemption Articulated in *Lockheed Air Terminal, Inc. v. City of Burbank*

Alan Armstrong\*

### I. INTRODUCTION

How many times have we read in briefs, trial court orders, or in our own submissions to the court that include discussions about express preemption, field preemption, and conflict preemption? Aviation litigators argue preemption very frequently. A subset and related element to preemption is an unreasonable burden on interstate commerce. We know under Article VI to the Constitution of the United States of America that the laws of the United States are the supreme law of the land. We further understand that Article I, Section 8, Clause 13 gives Congress the authority to regulate commerce. While the author has read on numerous occasions the Supreme Court decision in *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U. S. 624 (1973), I thought it would be interesting to review the trial court decision in *Lockheed Air Terminal, Inc. v. City of Burbank*, 318 F. Supp. 914 (C. D. Cal. 1970). A careful reading of the order of District Judge Crary in the case that was the genesis of a holding that matured into the Supreme Court's decision afforded insight and greater appreciation for the tenants that support federal preemption and arguments that state regulations or laws unreasonably burden interstate commerce. Consequently, if you permit me, we will revisit the decision of Judge Crary in *Lockheed Air Terminal, Inc., v. City of Burbank, supra*.

### II. THE EFFECTED PARTIES AND PARTICIPANTS IN THE LITIGATION

Originally, there were two plaintiffs in *Lockheed Air Terminal*. The first was Lockheed Air Terminal, Inc., a Delaware corporation that owned and operated Hollywood-Burbank Airport (KHBA). The second original plaintiff was Pacific Southwest Airlines, which was a corporation organized under the laws of California and doing business in Los Angeles. The Air Transportation Association of America (ATA) intervened as a plaintiff representing 32 members which was virtually all the United States scheduled air carriers at the time. Additionally, an amicus brief was filed by the United States on behalf of the Federal Aviation Administration.

The Defendants were the City of Burbank, a municipal corporation in Los Angeles County, California, the Mayor of the City, the Vice-Mayor of the City, a host of elected councilmen, the city attorney, and the Chief of Police of the City of Burbank. The Hollywood-Burbank Airport occupied approximately 535 acres, of which 128 acres were owned by the United States Government. The airport lay primarily in the city of Burbank and partially in the city of Los Angeles. The City of Burbank California had a population of 95,000 people at the time the case originated in Federal District Court where the Plaintiffs sought injunctive relief with respect to Burbank Municipal Code §20-32.1 which provided:

(a) Pure Jets Prohibited from Taking Off Between 11:00 P.M. and 7:00 A.M.

It shall be unlawful for any person at the controls of a Pure Jet Aircraft to take off from the Hollywood-Burbank Airport between 11:00 P.M. of one day and 7:00 A.M. the next day.

(b) Airport Operator Prohibited from Allowing Take-Offs.

It shall be unlawful for the operator of the Hollywood-Burbank Airport to allow a pure jet aircraft to take off from said airport between 11:00 P.M. of one day and 7:00 A.M. the next day.

318 F. Supp. At 916-17. As part and parcel of Judge Crary's order granting injunctive relief, he noted:

The Defendant officials of the City of Burbank have publicly announced their intention to enforce the curfew ordinance.

*Id.* at 917. Judge Crary further noted that Pacific Southwest Airlines held a certificate of public convenience and necessity from the California Public Utilities Commission and also held an air carrier operator certificate issued by the Federal Aviation Administration. *Id.* at 917. The operations specifications issued to Pacific Southwest Airlines allowed it to engage in regularly scheduled air carrier operations that included uses at the Hollywood-Burbank Airport. *Id.*

Judge Crary did a good job of explaining how aircraft operate at airports with control towers and approach control and engaged in a discussion about the necessity of receiving clearances from air traffic control and complying with those clearances as well as explaining the runway orientation of the four runways of the airport, Runway 7/25 and Runway 33/13. *Id.* at 919-20. He further noted that jet aircraft were required to maintain an altitude of at least 1,500 feet above the airport surface until a descent was required for landing. *Id.* at 920.

Historically, Pacific Southwest Airlines had operated a flight departing from Hollywood-Burbank Airport to San Diego Airport departing at 11:30 p.m. each Sunday night. *Id.* at 920. Despite the passage of the ordinance, the City of Burbank had permitted Pacific Southwest Airlines to operate a Monday through Friday flight departing Hollywood-Burbank Airport at 6:40 a.m. destined for Palmdale, California. *Id.*

### **III. A REVIEW OF THE ARGUMENTS MADE BY THE PLAINTIFFS**

The Plaintiffs argued that the City of Burbank ordinance was invalid for three reasons. The first reason was that the field had been occupied by federal statutes that precluded the promulgation of the ordinance. The second argument was that the ordinance conflicted with federal laws and regulations. The third and final argument was that the ordinance was an unreasonable burden on interstate commerce.

In response, the City of Burbank took the position that the ordinance was nothing more than a land use regulation and that it could control Lockheed's use of the airport with respect to its land use. *Id.* The City of Burbank maintained that its ordinance was reasonable because it only had an effect on flights out of Hollywood-Burbank Airport during curfew hours and only on intrastate carrier operations. *Id.* It further noted that the operations that Pacific Southwest Airlines was allowed to engage in by virtue of the authorization from the California Public Utilities Commission were intrastate. *Id.*

### **IV. THE COURT'S PRONOUNCEMENT AND ANALYSIS**

Judge Crary, relying on Senate Report 1811 of the 1958 FAA Act, noted that one of the reasons for the creation of the FAA was expressed as follows:

The present legislation proposes to clear away this ambiguity [airspace allocation] once and for all by vesting unquestionable authority for all aspects of airspace management in the Administrator of the new Agency.

*Id.* at 921.

While the City of Burbank relied upon *Huron Portland Cement Co. v. Detroit*, 362 U.S. 440, 80 S. Ct. 813, 4 L. Ed. 2d 852 (1959), where the Supreme Court found that a Detroit ordinance involving smoke abatement was valid, Judge Crary noted he would decide whether the ordinance imposed an unreasonable burden on interstate commerce. *Id.* at 922.

Another case decided by Judge Crary in his analysis was *Napier v. Atlantic Coast Line Railroad Co.*, 272 U.S. 605, 47 S. Ct. 207, 71 L. Ed. 432 (1926), where a Georgia statute required curtains and automatic firebox doors on locomotives while the regulations of Interstate Commerce Commission did not require such protections. *Id.* at 922. The net effect was that the Georgia statute was preempted, because the federal government had evidenced its intention to occupy the field. *Id.* at 922. Judge Crary noted there were three elements to consider in a preemption argument. The first question was whether “[t]he scheme of federal regulation may be so pervasive as to make reasonable the inference that congress left no room for the states to supplement it.” The second question was whether “...the Act of Congress may touch a field in which the federal interest is so dominant that the federal system will be assumed to preclude enforcement of state laws on the subject. *Id.* at 922. The final and third consideration of Judge Crary and his analysis was whether “...the state policy may produce a result inconsistent with the objective of the federal statute.” These three standards appear to be more or less expressions of (1) express preemption, (2) field preemption, and (3) conflict preemption.

To the extent that field preemption was a significant element in his analysis, Judge Crary noted:

From the broad scope of federal statutes and regulations governing and controlling the use of airspace and of air traffic, it would appear that Congress intended to centralize full and dominant control of the navigable airspace in the Federal Government so as to provide for its safe and most efficient use.

*Id.* at 925.

Considering conflict preemption as a basis for his analysis, Judge Crary, relying upon *American Airlines, Inc. v. Town of Hempstead*, 272 F. Supp. 226, (D.C., E.D. N.Y. 1967) noted: “local noise control legislation limiting permissible noise level of an overflying aircraft has recently been struck down because it conflicted with Federal regulation of air traffic.”

In addition to considering conflict preemption in his analysis, Judge Crary also commented on the implications of improper burdens on interstate commerce when he noted: “In viewing the effect of the [Burbank ordinance] with respect to preemption and the Commerce Clause issues, it appears that the Ordinance should be considered from a national level.” *Id.* at 926.

Continuing in his analysis, Judge Crary relied upon three central concepts for finding that the City of Burbank ordinance should be enjoined from enforcement, these concepts being field preemption, conflict preemption, and undue burdens on interstate commerce. *Id.* at 926-927.

With regard to the concept of field preemption, Judge Crary noted:

The Federal regulation of air navigation and air traffic is so complete that it leaves no room for local legislation as the Hempstead ordinance. *Id.* at 926.<sup>1</sup>

Next, and again quoting from *American Airlines v. Hempstead*, *supra*, Judge Crary noted:

Local initiative in noise control of aviation is inherently an effort to regulate a consequence while disclaiming regulation of the cause. It cannot coexist with a comprehensive system of federal regulation of aircraft manufacture (through certificates of airworthiness) and federal regulation of air navigation and air traffic.

*Id.* at 926.

Finally, with regard to the undue impact on interstate commerce, Judge Crary noted that the net effect of validating the City of Burbank ordinance would be to restrict flight operations of aircraft to only 12 hours per day, the result of which would necessitate the airlines purchasing more airplanes, erecting additional maintenance facilities, and dramatically increasing operational costs.

*Id.* at 927.

## V. CONCLUSION

The decision of Judge Crary in *Lockheed Air Terminal, Inc. v. City of Burbank*, *supra* is a meaningful exposition on the tenants of preemption and undue burdens on interstate commerce. In rendering his decision, Judge Crary laid the groundwork for Justice Douglas who authored his landmark opinion in *City of Burbank v. Lockheed Air Terminal, Inc.*, *supra*. It is gratifying to go back in history and read early cases which served as the foundation for the development of the law as we know it today.

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1Obviously, in making reference to the Hempstead ordinance, Judge Crary was referring to *American Airlines, Inc. v. Town of Hempstead*, 272 F. Supp. 226 (D.C., E.D., N.Y., 1967).

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